Final
Meeting Minutes

Governor's Electronic Health Records Task Force
Executive Directive 6 (2005)

Subcommittee #4 - Technology, Interoperability, Governance, Policy, and Legal Issues in EHR

August 19, 2005 1-3 pm
Patrick Henry Building, Governor's Conference Room

The meeting was called to order by Secretary Eugene Huang, Subcommittee Chair, at approximately 3:05 p.m. Subcommittee members in attendance were:

- Barbara Baldwin – UVA Health Systems
- Jeff Burke – Bon Secours Health Systems
- Steve Farmer -- Anthem Southeast, Inc.
- Tom Hanes – Sands Anderson Marks Miller
- David Hollins – Hospital Corporation of America
- Secretary Eugene Huang – Secretary of Technology
- Rick Mears – Owens and Minor
- Carl Gattuso – VCU Health Systems
- Becky Snead – Virginia Pharmacists Association

Due to scheduling conflicts, absent subcommittee members were:

- John O'Bannon – Neurologist and Member of the Virginia House of Delegates

Presenters in attendance were:

- Katherine Gianola, M.D. – Associate Chief of Staff for Information Technology and TeleHealth, Hunter Holmes McGuire Veterans Affairs Medical Center and Assistant Professor of Internal Medicine, MCV/VCU
- James Lapsley – CEO, Loudon Medical Group, PC
- Katie Roeper – Executive Director, Senior Navigator
- James Burns, M.D. – Deputy Commissioner for Public Health Programs and CIO, Virginia Department of Health

Presenters attending via teleconference were:

- William Braithwaite, MD, PhD, FACMI – eHealth Initiative

Subcommittee Staff in attendance were:

- Debbie Secor – VITA Enterprise Service Director, Health and Human Services Secretariat
- Thomas Gates – Special Assistant, Office of the Secretary of Technology
- Craig Surro – Special Assistant, Office of the Secretary of Health and Human Resources

MEETING AGENDA

- Approve Draft Minutes of July 25 Meeting and Revised Subcommittee Work Plan:

  Minutes and the revised subcommittee work plan were approved as presented.

- Presentations:

  Secretary Eugene Huang welcomed all the presenters to the meeting and thanked them for sharing their knowledge and expertise with the subcommittee.

  - Katherine Gianola, M.D. – Connecting V.A. Hospitals with VISTA

  VISTA is a free computerized records management system that is currently being utilized within a network of eight V.A. hospitals. The system itself, which was demonstrated through a live connection to a hospital, includes several modules. The physician can document and include in the system a patient's vital signs within particular timeframes, inter-facility consults, medications dispensed and the results of laboratory tests. In addition, the system creates a variety of alerts; one such alert notifies physicians when there is a patient allergy, for example. The system can be used to order medications using an internal pharmacy. These orders are automatically sent to the internal pharmacies or lab. The system can be accessed from any remote location via VISTAweb.

  Positive impacts as a result of system implementation include: enhanced patient safety, order checks and alerts, legibility, accountability and timeliness, concurrent provider chart use, better continuity of patient care, decreased verbal order usage, enhanced provider satisfaction and improved medical record documentation.

  Lessons learned and tools for successful implementation include: a staged deployment, use a GUI format, seek out super-users and champions, encourage clinical application coordination (nurses and pharmacies), implement a very strong security program and have standing committees in place to address issues as they arise. Finally, it is essential to

develop a backup system and have contingencies in place so that patient care is not compromised.

Questions/Comments:

1. How is data from other systems brought into VISTA? DOD records are currently available. Some data is scanned into the system.
2. Are there any arrangements with external pharmacies? Most orders are filled through internal pharmacies.
3. How many FTE's are supporting the system? There are approximately 2200 end-users and there are 4 FTE's supporting the system. There are other people who provide some support but have other responsibilities. It is important to have a full-time Information Security Officer in place.
4. Is voice recognition software used at all? This has been tried but did not work out due to ambient noise within hospitals.
5. How much training would be required for doctors who have never seen the system? There is a very short learning curve; end-users received approximately 4 hours of training with periodic updates as needed.
6. Is billing included? Not yet. There are however, third party vendors who will provide this service.

- James Lapsley, CEO, Loudon Medical Group, PC -- Connecting Providers Across Northern Virginia with AllScripts

Loudon Medical Group began their electronic medical records implementation two years ago across fifty locations through a wide area network. The first priority was to eliminate charts and as much paper processing as possible. Putting an electronic medical records system in place is a huge undertaking and is an even larger cultural change for physicians. This must be managed throughout implementation. The decision was made here to implement the entire medical records system by location before moving onto another location. There should be an interface with billing and accounts receivable, however this interface is not easy.

Prior to implementation, Loudon Medical Group spent two years evaluating EMR's. There are many products available in the market today. AllScripts was the system Loudon settled on. Once a system is selected, it is essential to engage physicians in the planning process as best as possible. Having physicians sit on steering committees has been helpful. The return on investment on this project is not favorable. This will cost the Loudon Medical Group revenue due to the fact that physicians are not able to see as many patients; however they are hopeful that this will last only through the phased implementation period. The use of the EMR will not reduce staff either due to the fact that there will be staff needed to scan in patient information that is not available electronically. The implementation process for any EMR is slow and involves a major cultural change.

The main challenges for the Loudon Medical Group include trying to choose from so many different products, implementation and training.

Questions/Comments:

1. Is there any plan to interface with labs or other hospitals throughout the area? This is extremely expensive; around 30-40K per interface.
2. What about disaster recovery? Loudon Medical Group contracted with a vendor who provides a server farm for backup purposes. There is T1 redundancy as well.
3. Any suggestions to cope with cultural issues? Engage physicians early in the process. Take the time to choose the right product. Offer incentives.

- Katie Roeper – Connecting Virginia Seniors to Services through a UAI

Senior Navigator is a nonprofit organization that provides information services to Senior citizens. A database of senior services is provided and is accessible through a website. There is also a community component offered that does not include technology. Senior Navigator is working with Virginia to provide services to seniors through a universal assessment instrument. This is part of the "No Wrong Door" program endorsed by Virginia. Secretary Jane Woods has pulled together a committee to oversee the project. The committee consists of representatives from many Agencies across Virginia. There are currently three pilot projects underway – Peninsula Area, Greater Richmond Area and the Shenandoah Area. The committee is currently working on ways to deliver services to seniors, however there is interest in sharing information between EMR's and Senior Navigator.

Questions/Comments:

1. Any plans to move the program to the western part of the state? Already identifying other communities to roll this out.
2. What is used as the patient's unique identifier? Enter the patient's name and social security number and the system returns a unique identifier.

- Dr. William Braithwaite – Interoperability from a National Perspective

In looking at the three presentations already given, it is interesting to consider how interoperability could be achieved. Interoperability is critical for the success of any EMR. According to HL7, the definition of interoperability is "to exchange information and utilize information in ways that are accurate and verifiable when and where needed." This is not a clear or simple concept. Asking systems to exchange information when there is no connection is almost impossible.

In order to achieve interoperability, there are several qualities that need to be in place. These include:

- Trust – must come to an agreement or contract where different organizations agree to share information in certain ways and to certain degrees.
- Finances – how will the exchange of information be financed? Who will pay for what?
- Technical standards – must agree on standards, formats and structures. HL7 serves as a basis for this. By next August, the HL7 group will release a standard method to move data across systems.

Finally, as stated, connecting across systems is a huge problem. The standards released by the HL7 group is a good format for this committee to use.

- Dr. James Burns – Report from Association of State and Territory Health Officials

A conference call was recently held with the members of the Association of State and Territory Health Officials (ASTHO). There were several states represented. They reported the following including Indiana, Minnesota, Rhode Island, Utah, Kentucky, New Hampshire, Pennsylvania, Virginia and Wisconsin.

- Indiana – 2 RHIO's have been formed.
- Minnesota – There is an e-Health Steering Committee in place. The priority areas in which to share information are medications, communicable diseases and laboratory results.
- Rhode Island – the AHRQ project is trying to establish interoperability across the state through the use of a master patient index.
- Utah – the Utah Health Information Network is in place. One hundred percent of hospitals use this for claims while 90% of physician the network for claims.
- New Hampshire – community health centers use the same EMR; partnering with Medicaid to look at data sharing.
- Wisconsin – an estimated 35% of practices have an EMR.

In summary, everyone is struggling; there are no easy answers; developing a system takes a long time; and an EMR is expensive, so funding needs to be in place.

This concluded the presentations.

In other business, Secretary Huang asked committee members to send in a brief summary of 3 or 4 of the most exciting health initiatives underway in their respective areas. This information should be sent to Craig Surro by August 29th.

There being no further business, the meeting was adjourned at approximately 3:25pm.